PUBLIC GOODS POOL
GENERAL INSTRUCTIONS FOR COMPLETING
PAYOR ANNUAL REPORTING FORMS

IMPORTANT NOTE: HARDCOPY ANNUAL REPORTS CAN ONLY BE USED FOR REPORTING PERIODS PRIOR TO JANUARY 1, 2005. ALL ANNUAL REPORTS COMMENCING JANUARY 1, 2005 MUST BE SUBMITTED ELECTRONICALLY.

Payors that have elected to remit their public goods liability directly to the Department's Office of Pool Administration are required to use hardcopy forms or file electronically to calculate and remit the annual payment to the Public Goods Pools. Prior service year portions of the reports are available on the WEB at:

www.health.state.ny.us/nysdoh/hcra/hcrahome.htm

If you were previously advised by the Department that your organization meets the criteria for filing an annual Public Goods Pool report and payment for the current reporting year and you did not timely submit the supplied form to the Office of Pool Administration to change your filing designation from annual to monthly, you must file an annual Public Goods Pool report and payment, even if you erroneously continued to file monthly reports for the reporting year.

The reports and payments must be submitted to the Office of Pool Administration on or before the 30th day following the last day (December 31st) of the reporting year, adjusted for weekends and holidays. Since payors cannot determine their annual Public Goods Pool liability until sometime following the last day of the reporting year, all annual reports submitted prior to the end of the reporting year will be returned.

TPAs submitting reports on behalf of annual and monthly filers, must submit the annual reports separate from the monthly reports. Reports submitted on behalf of annual filers may not be combined with reports filed on behalf of monthly reporters. Further, if an annual reporting submission represents a consolidated report filed on behalf of a parent company with a number of subsidiaries, the parent company and each represented subsidiary must have been notified by the Department that they qualify for annual reporting. Subsidiaries that have not qualified for annual reporting must file separate monthly reports.

A payor's annual report must be a composite of 1) all patient services payments made during the reporting year, 2) the number of monthly New York State resident covered lives on the payor's membership roles for all or any part of a month summarized for the entire year, 3) all reporting adjustments due to prior reporting errors or omissions, and 4) the related surcharge and assessment amounts. If an annual reporter erroneously submitted monthly reports and payments during the current reporting year, the payor's annual report must be net of the patient services payments and covered lives amounts reported on the monthly reports erroneously submitted.

Generally, annual reporters must submit the enclosed Payor Certification Form and the two most recent service year portions of the Report of Patient Services Payments and Report of Covered Lives Assessment[1] (exceptions are noted in the following paragraph), even if there is no activity to report. Prior service year

[1] Corporations organized and operating in accordance with Article 43 of the Insurance Law; organizations operating in accordance with the provisions of Article 44 of the Public Health Law; self-insured funds; and commercial insurers licensed to do business in New York State and authorized to write accident and health insurance and whose policy provides coverage on an expense incurred basis are required to pay the professional education pool surcharges or the covered lives assessment.

Payors not specifically mentioned above do not have a professional education pool surcharge or covered lives assessment obligation; therefore, such payors electing direct payment to the Department's pool administrator are not required to complete the Covered Lives Assessment Report.

portions of the report are required only when a payor has net patient services payments and/or prior period adjustments to report which relate to those service years. Prior service year portions of the report are available on the WEB at: www.health.state.ny.us/nysdoh/hcra/hcrahome.htm.

A payor's Public Goods Pool reporting submission must include only those surcharge and/or covered lives payment obligations relating to the service period during which the payor is an electing payor. Payors must continue to remit surcharge obligations, relating to service periods that are not covered by a valid election, directly to designated providers of services. For example, payors whose elections to remit surcharges directly to the Public Goods Pool do not become effective until January 1st of the current reporting year do not report their surcharge/assessment obligations for the previous service years on the Public Goods Pool report forms since they are required to continue to remit any applicable surcharges/assessments for such service years to designated providers of services. Conversely, payors that rescind their election effective December 31st of the previous reporting year do not report their surcharge/assessment obligations for subsequent service years on the Public Goods Pool report forms since they are required to remit any applicable surcharges for such service years to designated providers of services.

Further, a payor's Public Goods Pool reporting obligation does not cease when the payor rescinds its election application. The payor's Public Goods Pool reporting obligation, for the service period during which the entity was an electing payor, will continue for a period of one year following the end of the year in which the election was rescinded or until all claims for such service period have been adjudicated. Once all claims have been adjudicated, the payor must submit a final report and a completed Attachment 2.5 indicating the effective date when all claims were adjudicated. Additionally, a payor's Public Goods Pool reporting obligation does not cease when the payor has a change of status (i.e., self-insured to fully insured). For important information concerning a payor's reporting obligations when the payor has a change of status, please refer to the forms located on the WEB.

Pursuant to the New York Health Care Reform Act of 1996, each service year's pool receipts are dedicated to specific purposes and in specific amounts. As a result:

- The Annual report filed by payors must segregate patient services payments and the related surcharges into service year portions. For example, payors must include total patient service payments for services provided in 2002 in the 2002 portion of the report even if such payments are made in a subsequent service year. In addition, any prior period adjustments must be reported in the service year section of the report to which they apply. For example, a correction for an amount reported for service year 2002 must be reported as a prior period adjustment on the 2002 portion of the report.
- The Annual report filed by payors must segregate covered lives and related assessments into service year portions. Thus, adjustments necessary to covered lives information reported during a prior year must be reported on the appropriate year's form. For example, an adjustment for covered lives information reported during 2002 must be reported on the 2002 portion of the Report of Covered Lives Assessment. Under **no** circumstances should adjustments to covered lives payments reported for prior years be included in the current service year portion of the report.

Note that the guidance offered in these instructions is not all-inclusive. Please refer to the New York Health Care Reform Acts and related correspondence previously disseminated by the Department, which is available on the HCRA website.

PAYOR CERTIFICATION FORM

REPORT YEAR: Enter year for which data is being reported.

PAYOR NAME: Enter name of payor that was notified by the Department that they qualify for annual reporting. The payor name is that of the incorporated entity, local government, or self-insured fund for which data is being reported. Enter the parent company name if the reporting submission applies to a parent company. Enter "See Attachment 1", if the reporting submission applies to a third-party administrator (TPA) and its represented organizations.

ADDRESS: Enter address of payor.

FED. TAX ID #: Enter federal identification number used by payor for federal tax purposes.

TPA NAME/TPA FED. TAX ID #: Enter name of third party administrator (TPA) and their federal tax identification number, if payor utilizes a TPA for claims processing and payment.

COMPLETED BY/TITLE/TELEPHONE: Enter name, title and telephone number of the person who will be responsible for providing the Department related information regarding the payor's report form(s).

TYPE OF SUBMISSION: Check appropriate box to specify whether the certification and reporting submission is for 1) an insurer or self-insured fund acting on its own behalf; 2) a TPA and all of the represented organizations listed on Attachments 1 and 2; or 3) a parent company and all its related subsidiaries listed on Attachment 1.

REPORTING REQUIREMENTS: Indicate whether the certification and reporting submission pertains to the Report of Patient Services Payments and Surcharge Obligations and/or Report of Covered Lives Assessment by checking any appropriate box(es).

CERTIFICATION: Enter name and title of person who is certifying to the accuracy and correctness of the report form(s) submitted. Enter name of organization that employs the person signing the Certification form.

- Where the information being certified to has been supplied to a TPA by another entity, the TPA must obtain and maintain for audit purposes an attestation statement from an authorized person of such entity to the effect that the information is accurate and correct to the best of their knowledge and belief. **Note: Authorized persons would be any person who is empowered to legally bind the organization to such commitments.**

SIGNATURE/DATE: The person responsible for certifying the accuracy and correctness of the report form(s) submitted must sign and date the Certification form.

PRINT FULL NAME: Print or type name of person responsible for certifying the accuracy and correctness of the report form(s) submitted.

TELEPHONE NUMBER: Provide telephone number of individual signing the certification.

ATTACHMENT 1
TPA/Parent Company Reporting Forms - Identification of Represented Organization/Subsidiary Reporting Forms for Represented Entities that Were Notified by the Department that They Qualify for Annual Reporting

REPORT YEAR: Enter year for which data is being reported.

TPA OR PARENT COMPANY NAME/FEDERAL TAX ID #: Enter parent company name and federal tax identification number if the reporting submission applies to a parent company. Enter TPA name and federal tax identification number if the reporting submission applies to a TPA.

CONTACT/TELEPHONE #: Enter name and telephone number of person who will be responsible for providing the Department related information regarding the payor's report form(s).

PAYOR TYPE: Check appropriate box.

ORGANIZATION NAME/FEDERAL TAX ID#: List name and federal tax identification number of each entity that was notified by the Department that they qualify for annual reporting and is being reported by the Parent Company or TPA.

TPAs only - For each entity listed, check the type of report(s) submitted and payment method (separate or combined check) by year. You must check at least one of the report type boxes (Patient Service Payment Report or Covered Lives Report) for the current and previous service years. Where a TPA is submitting a consolidated report on behalf of a parent company with a number of subsidiaries, the TPA must list the name and federal tax identification number of the parent company and each subsidiary. A separate Attachment 1 must be completed for each parent company.

ATTACHMENT 2
TPA Summary of Represented Electing Entities With No Public Goods Liability for Represented Entities that Were Notified by the Department that They Qualify for Annual Reporting

REPORT YEAR: Enter year for which data is being reported.

TPA NAME/FEDERAL TAX ID #: Enter name of TPA and their federal tax identification number.

CONTACT/TELEPHONE #: Enter name and telephone number of person who will be responsible for providing the Department related information regarding the payor's report form(s).

ORGANIZATION NAME/FEDERAL TAX ID#: List name and federal tax identification number of each represented entity that 1) was notified by the Department that they qualify for annual reporting **and** 2) has no activity to report for the reporting year or is submitting the reporting forms separately on its own behalf. Where a TPA is representing a parent company with a number of subsidiaries, the TPA must list the qualifying parent company and each represented subsidiary that 1) was notified by the Department that they qualify for annual reporting **and** 2) has no activity to report for the reporting year or is submitting the reporting forms separately on its own behalf.

List only those entities that have no activity to report for the year for all HCRA service periods (i.e., commencing with the 1997 service period through the current service period) and/or those entities that are submitting the Certification and reporting forms on their own behalf. Annual payors that erroneously submitted one or more monthly reports during the current reporting year may only be listed on Attachment 2 if they have 1) no additional patient services payments to report; 2) no additional New York State resident covered lives to report or no statutory obligation to the Professional Education Pool; and 3) no additional adjustments to patient services payments and/or covered lives information previously reported. If an entity has activity to report for one or more HCRA service periods, the entire report must be completed in accordance with the instructions.

IMPORTANT NOTE: Do not list payors that have no covered lives liability or credit for the reporting year due to apportionment on this attachment. Payors that apportion the cost of their covered lives assessments with another payor must report the covered lives subject to apportionment and their respective apportionment percentage on Lines C through H of the Report of Covered Lives Assessment. The Report of Covered Lives Assessment must be completed even where the payor's apportionment percentage is zero.

For each entity listed, enter an "X" in the appropriate box under each of the categories provided (i.e., Patient Service Payments and Covered Lives).

REPORT OF PATIENT SERVICES PAYMENTS AND SURCHARGE OBLIGATIONS

GENERAL INSTRUCTIONS

On the top of the form, check all the reporting circumstances which apply.

For the current service year portion of the report:

Box 1: Enter an "X" if the payor has made no patient services payments for services rendered during the current service year. If an annual reporter erroneously submitted monthly reports during the current reporting year**,** enter an "X" if the payor has no additional patient services payments to report for services rendered during the current service year **and** no additional adjustments to patient services payments previously reported for the current service year.

Box 2: Enter an "X" if the payor has a) no statutory obligation to the Professional Education Pool or b) a statutory obligation to the Professional Education Pool but had no covered lives of residents of New York State during the current service year. **IMPORTANT NOTE**: Only those payors that a) are NOT specifically mentioned in PHL Section 2807-s (1-a)(b) as having a professional education pool surcharge or covered lives obligation or b) had no New York State residents on their membership rolls for all or any part of the year may check this box. This box may not be used where a payor's share under an apportionment agreement is zero. Payors that apportion their covered lives obligations with another payor must report the covered lives subject to apportionment and their respective apportionment percentage on Lines C through H of the Report of Covered Lives Assessment**.** If an annual reporter erroneously submitted monthly reports during the current reporting year**,** enter an "X" if the payor has a) no statutory obligation to the Professional Education Pool or b) a statutory obligation to the Professional Education Pool but no additional New York State resident covered lives to report for the current service year **and** no additional adjustments for covered lives information previously reported for the current service year.

Box 3: Enter an "X" if the payor's Report of Covered Lives Assessment is being submitted separately by the fund or a TPA.

For the previous service year portion of the report:

Box 1: Enter an "X" if the payor has made no patient services payments during the reporting year for services rendered during the previous service year and has no adjustments to patient services payments previously reported for the previous service year. If the annual reporter erroneously submitted monthly reports during the current reporting year**,** enter an "X" if the payor has no additional patient services payments to report for services rendered during the previous service year **and** no additional adjustments to patient services payments previously reported for the previous service year.

Box 2: Enter an "X" if the payor has no adjustments for covered lives information previously reported for the previous service year. If the annual reporter erroneously submitted monthly reports during the current reporting year**,** enter an "X" if the payor has no additional adjustments for covered lives information previously reported for the previous service year.

Box 3: Enter an "X" if the payor's Report of Covered Lives Assessment is being submitted separately by the fund or a TPA.

Note that report heading definitions below apply to all service years.

REPORT YEAR: Enter year for which data is being reported.

PAYOR NAME: Enter name of payor that was notified by the Department that they qualify for annual reporting. The payor name is that of the incorporated entity, local government, or self-insured fund for which data is being reported.

FEDERAL TAX ID#: Enter federal identification number used by the payor for federal tax purposes.

TPA NAME/TPA FEDERAL TAX ID #: Enter TPA's name and federal tax identification number, if the payor utilized a TPA for claims processing and payment.

COLUMNAR DESCRIPTIONS

Column A - Description: This column itemizes total patient services payments and the related surcharge liability. Note: Refer to Payor Report for applicable surcharge percentage.

Patient services payments subject to the surcharges include all monies paid during the reporting year to designated providers of service, including capitation payments allocable to the particular service, less refunds, for discharges occurring or for visits made or services performed on or after January 1st, or contracted service obligations for periods on or after January 1st, of the report service year.

Excluded from surcharge requirements are payments for physician practice or faculty practice plan discrete billings for private practicing physician services, laboratory tests performed on laboratory specimens collected outside New York State, residential health care facility services, inpatient and outpatient hospice services, adult day health care services, home care services, services provided to subscribers of a Health Maintenance Organization (HMO) operating in accordance with Article 43 of the Insurance Law or Article 44 of the Public Health Law in situations where such HMO operates the clinic or laboratory providing the service (this applies

whether or not such services are covered services by the HMO). Services provided to Medicare beneficiaries are also excluded except where a payor is making payments to a designated provider of service as a result of a person's exhaustion of Medicare benefits, or lack of Medicare benefits for a particular service. In these instances, the services are subject to the surcharge. Additionally, payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA are excluded from the surcharge requirements.

Pursuant to the provisions of the New York Health Care Reform Act of 2000 (HCRA 2000), surcharges are eliminated for referred ambulatory clinical laboratory hospital visits made or services performed on and after October 1, 2000. Referred (ordered) ambulatory care laboratory services are defined as clinical laboratory services provided to non-registered patients upon the order and referral of a qualified physician, physician's assistant, dentist, or podiatrist to test or diagnose a specimen taken from a patient. For purposes of the specific service being ordered for a specific patient, the specified provider ordering the service may not be employed by or under contract to provide direct patient care for the facility.

Referred (ordered) ambulatory care laboratory services do not include clinical laboratory services provided to a patient admitted to any of such hospital's inpatient units; an emergency outpatient defined as one who is admitted to the emergency, accident or equivalent service of the hospital (Title 10, Sect. 441.104); nor clinical laboratory services provided to a clinic outpatient defined as one who is registered with a formally organized hospital service unit known as a clinic (Title 10, Sect. 441.65).

Column B - Inpatient Hospital: This column is to be used to report patient services payments and the related surcharge liability for all inpatient services provided by general hospitals.

Column C - Outpatient Hospital: This column is to be used to report patient services payments and related surcharge liability for all outpatient services provided by general hospitals including referred ambulatory services, emergency services, ambulatory surgical services, hospital based laboratory services and all other hospital and health-related services. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in either Column C or Column E (Comprehensive Primary Health Care Clinic).

Column D - Freestanding Ambulatory Surgery: This column is to be used to report patient services payments and the related surcharge liability for all ambulatory surgical services of freestanding diagnostic and treatment centers providing ambulatory surgical services. Note that payments to a comprehensive primary health care clinic for ambulatory surgical services must be reported in Column E (Comprehensive Primary Health Care Clinic).

Column E - Comprehensive Primary Health Care Clinic: This column is to be used to report patient services payments and the related surcharge liability for all services of freestanding diagnostic and treatment centers providing a comprehensive range of primary health care services. Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in either Column E or Column C (Outpatient Hospital).

Column F - Freestanding Clinical Laboratory: This column appears only on the 1997 through 2000 service year portions of the report since it is to be used to report patient services payments and the related surcharge liability for or on account of clinical laboratory visits made or services (relating to human specimens) performed

prior to October 1, 2000[2], by freestanding clinical laboratories issued a permit pursuant to Title V of Article 5 of the Public Health Law**.** Note that payments to hospital based laboratories or laboratories housed in comprehensive primary health care clinics must be reported in Column B (Hospital Outpatient Services) and Column E (Comprehensive Primary Health Care Clinic), respectively.

A list of the aforementioned designated providers subject to the surcharges is available on the WEB. Please note however, that the list of freestanding clinical laboratories may include clinical laboratories owned and operated by hospitals and comprehensive primary health care clinics.

LINEAR DESCRIPTIONS

Instructions apply to both service year portions of the Report of Patient Services Payments and Surcharge Obligations.

Line 1 - Patient Services Payments Subject to the Surcharge: The following instructions apply to Lines 1(a) through 1(d).

Line 1(a) - Current Year: This line is to be used for reporting all patient services payments made during the current reporting year that are subject to the surcharge (for services rendered during the specified service year). If the payor erroneously submitted monthly reports during the current reporting year, Line 1(a) of the annual report must be net of the patient services payment amounts reported on Line 1(a) of the monthly reports erroneously submitted for the specified service year.

Payments must be reported according to the categories listed in Columns B through E. Patient services payments subject to the surcharge include payments to designated providers by New York State governmental agencies and local governmental agencies (of New York State) **ONLY** for services provided to correctional facility inmates. Also include patient services payments to designated providers by Health Maintenance Organizations (HMOs) or Prepaid Health Services Plans (PHSPs) for services provided to Medicaid beneficiaries enrolled in the HMO or PHSP and approved organizations for services provided to subscribers eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law.

Line 1(b) - Prior Period Adjustment: This line is to be used for reporting adjustments due to a prior reporting error or omission (for the specified service year) for patient services payments subject to the surcharge. Prior period adjustments do not normally apply to the current service year portion of the report. Therefore, there would not normally be any entries on Line 1(b) of the current service year portion of the report. However, if an annual reporter erroneously submitted monthly reports during the current reporting year and has reporting adjustments to patient services payments previously reported for the current service year, on those monthly reports, enter the required adjustment amounts on Line 1(b).

The adjustments must be reported according to the categories listed in Columns B through E. The adjustment amounts may be either positive or negative. Detailed records are to be maintained since all data is subject to audit.

If a payor does not normally segregate these amounts individually, but maintains net amounts only within the payor's books and records, the payor may report such net amounts on Line 1(c) only (i.e., Lines 1(a) and 1(b) need not be completed).

[2] Pursuant to the provisions of HCRA 2000, surcharges are eliminated for or on account of freestanding clinical laboratory services and on referred laboratory services provided by hospitals and/or comprehensive clinics on and after October 1, 2000 .

Line 1(c) - Adjusted Patient Services Payments: Line 1(a) plus or minus Line 1(b).

Line 1(d) - Surcharge Liability: Multiply the individual amounts on Line 1(c) by the applicable surcharge. Enter the result in the appropriate column on Line 1(d).

Line 2 - Patient Services Payments Subject to the Surcharge: The following instructions apply to Lines 2(a) through 2(e).

Line 2(a) - Current Year: This line is to be used for reporting all patient services payments made during the current reporting year that are subject to the surcharge (for services rendered during the specified service year). If the payor erroneously submitted monthly reports during the current reporting year**,** Line 2(a) of the annual report must be net of the patient services payment amounts reported on Line 2(a) of the monthly reports erroneously submitted for the specified service year.

Payments must be reported according to the categories listed in Columns B through E. Patient services payments subject to the surcharge include payments by corporations organized and operating in accordance with Article 43 of the Insurance law, organizations operating in accordance with the provisions of Article 44 of the Public Health Law, corporations that are commercial insurers licensed in New York State, self-insured funds, payors pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law, other insurers not licensed or organized under New York State statute, and any other rate, charge, or negotiated rate payment payor. Do not include payments for patient services provided to persons who are eligible for payments as beneficiaries of Title XVIII of the federal Social Security Act (Medicare) *except* where the payor has made payments to a designated provider of service as a result of a person's exhaustion of Medicare benefits, or lack of Medicare benefits for a particular service. In these instances, the services are subject to the surcharge and should be reported on this line. Additionally, do not include payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA.

Line 2(b) - Prior Period Adjustment: This line is to be used for reporting adjustments due to a prior reporting error or omission (for the specified service year) for patient services payments subject to the surcharge. Prior period adjustments do not normally apply to the current service year portion of the report. Therefore, there would not normally be any entries on Line 2(b) of the current service year portion of the report. However, if an annual reporter erroneously submitted monthly reports during the current reporting year and has reporting adjustments to patient services payments previously reported for the current service year, on those monthly reports, enter the required adjustment amounts on Line 2(b).

The adjustments must be reported according to the categories listed in Columns B through E. The adjustment amounts may be either positive or negative. Detailed records are to be maintained since all data is subject to audit.

If a payor does not normally segregate these amounts individually, but maintains net amounts only within the payor's books and records, the payor may report such net amounts on Line 2(c) only (i.e., Lines 2(a) and 2(b) need not be completed).

Line 2(c) - Adjusted Patient Services Payments: Line 2(a) plus or minus Line 2(b).

Line 2(d) - Surcharge Liability: Multiply the individual amounts on Line 2(c) by the applicable surcharge. Enter the result in the appropriate column on Line 2(d).

Line 2(e) – Co-Payment and Deductible Surcharge Payments: Enter all surcharges the third-party payor is remitting directly to the Department's Office of Pool Administration for patient co-payment and deductible payments, which would otherwise be paid to a provider in accordance with the second billing example on the Department of Health website at www.health.state.ny.us/nysdoh/hcra/examples.htm.

Payors to directly remit surcharge amounts attributable to patient co-payment and deductible payments must have procedures in place to adequately notify the billing provider of such action in a timely manner.

Line 3 - Total: Add the individual amounts on Lines 1(d), 2(d) and 2(e) and enter the result in the appropriate column on Line 3.

Line 4 - Total Surcharge Obligation on Patient Services Payments: Add the individual amounts on Line 3 and enter the result on Line 4.

REPORT OF COVERED LIVES ASSESSMENT

GENERAL INSTRUCTIONS FOR COMPLETING THE CURRENT SERVICE YEAR PORTION OF THE REPORT OF COVERED LIVES ASSESSMENT

On top of the form, check all the reporting circumstances which apply:

Box 1: Enter an "X" if the payor has a) no statutory obligation to the Professional Education Pool or b) a statutory obligation to the Professional Education Pool but had no covered lives of residents of New York State during the current service year. **IMPORTANT NOTE:** Only those payors that a) are NOT specifically mentioned in PHL Section 2807-s (1-a)(b) as having a professional education pool surcharge or covered lives obligation or b) had no New York State residents on their membership rolls for all or any part of the year may check this box. This box may not be used where a payor's share under an apportionment agreement is zero. Payors that apportion their covered lives obligations with another payor must report the covered lives subject to apportionment and their respective apportionment percentage on Lines C through H of the Report of Covered Lives Assessment. If an annual reporter erroneously submitted monthly reports during the current reporting year**,** enter an "X" if the payor has a) no statutory obligation to the Professional Education Pool or b) a statutory obligation to the Professional Education Pool but no additional New York State resident covered lives to report for the current service year **and** no additional adjustments for covered lives information previously reported for the current service year.

Box 2: Enter an "X" if the payor has made no patient services payments for services rendered during the current service year. If an annual reporter erroneously submitted monthly reports during the current reporting year**,** enter an "X" if the payor has no additional patient services payments to report for services rendered during the current service year **and** no additional adjustments to patient services payments previously reported for the current service year.

Box 3: Enter an "X" if the payor's Report of Patient Services Payments and Surcharge Obligations is being reported separately by the fund or a TPA.

Covered Lives - Lines (A) and (B): Enter the number of monthly individual covered lives and family unit covered lives (summarized for the entire year) residing in New York State during the reporting year, for whom the payor provides coverage for inpatient hospital services, which were included on the payor's membership rolls for all or any part of a month, by region. The payor must, pursuant to statute, determine and report the total number of individual and family unit covered lives on the membership rolls for each month during the reporting year, aggregate the results, and enter the sum for all months.

For example, if after the calculation, an annual filer had an aggregate of 1,200 individual covered lives on their membership roles for the first six months of the reporting year, and an aggregate of 240 individual covered lives for the last six months of the year, and three individual covered lives on their membership roles for two weeks during the month of January of the reporting year, then the payor would report 1,443 individual covered lives under the appropriate regional designation on Line (A) of this section of the report.

If an annual reporter erroneously submitted monthly reports during the current reporting year**,** Lines (A) and (B) of the annual report must be net of the covered lives amounts reported on Lines (A) and (B) of the monthly reports erroneously submitted.

Line (A) # Individuals: Enter the number of individual covered lives.
Line (B) # Family Units: Enter the number of family unit covered lives.

Apportionment of Covered Lives - Lines (C) through (H): For payors that have reached an agreement to apportion the cost of their covered lives assessments with another inpatient payor providing unduplicated coverage for a single contract holder, and only for those payors that submitted apportionment agreements as part of their election application, data would be entered in this section of the form. All apportioning entities must be electing payors and the resultant apportionment between such electing payors must add up to 100% of the covered lives being apportioned. The payor must identify the number of covered lives, from within the total number of covered lives reported in Section I on Lines (A) and (B), which are the subject of apportionment.

Line (C) # Individuals Subject to Apportionment: Enter the total number of individual covered lives subject to apportionment.
Line (F) # Family Units Subject to Apportionment: Enter total the number of family unit covered lives subject to apportionment.

The apportionment percentage is the percentage of assessment cost which the reporting entity will be paying in the HCRA period. Where a payor has multiple apportionment agreements, the apportionment percentage entered on Lines (D) and (G) should reflect a composite percentage weighted to reflect the relative number of covered lives in each agreement. An example weighted average apportionment calculation is provided on the last page of these instructions**.** The apportionment percentages reported must reflect the agreements the payors have on file.

Line (D) Apportionment Percentage: Enter the apportionment percentages for individual covered lives.
Line (G) Apportionment Percentage: Enter the apportionment percentages for family unit covered lives.
Line (E) Apportioned # of Individual Covered Lives: Line (C) x Line (D).
Line (H) Apportioned # of Family Unit Covered Lives: Line (F) x Line (G).

Net Covered Lives - Lines (I) and (J): Net covered lives after apportionment and before prior period adjustments are derived by the following calculation: total number of covered lives less covered lives subject to apportionment plus apportioned covered lives.

Line (I) Net # Individuals: (Line A - Line C) + Line E.
Line (J) Net # Family Units: (Line B - Line F) + Line H.

Net Covered Lives Prior Periods - Lines (K) and (L): Prior period adjustments do not normally apply to the current service year portion of the report; therefore, there would not normally be any entries on Lines (K) and (L) of the current service year portion of the report. However, if an annual reporter erroneously submitted monthly reports during the current reporting year and has reporting adjustments to covered lives information previously reported for the current service year, on those monthly reports, enter the number of covered lives under or (over) reported for prior periods (Prior Period Adjustments), by region. Prior period adjustments include retroactive additions and deletions to membership. Since covered lives payments are due for any plan participant on the membership rolls for all or any part of a month, retroactive deletions apply only when the individual or family unit is being retroactively deleted for full monthly periods.

For example, if one family unit covered life was originally included in the January through June monthly reports erroneously submitted during the current reporting year and was subsequently deleted effective January 5th, the payor would enter - 5 under the appropriate family unit regional designation on Line (L) of the annual report to reflect the deletion of one family unit covered life for five months (February through June). Further, the net number of monthly covered lives under or (over) reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. For example, if ten family unit covered lives that were included in monthly reports erroneously submitted were being retroactively deleted for one month and pursuant to an apportionment agreement this payor shared costs at a fifty percent (50%) level, only - 5 lives would be shown under the appropriate family unit regional designation on Line (L) of this section of the annual report.

Total Covered Lives - Lines (M) and (N): Carry forward the amounts reported on Lines (I) and (J), unless the annual reporter erroneously submitted monthly reports during the current reporting year. If an annual reporter erroneously submitted monthly reports during the current reporting year and the payor reported adjustment amounts on Lines (K) and (L), add the regional amounts reported on Line (I) to the respective amounts reported on Line (K) and enter the result on Line (M) and add the regional amounts reported on Line (J) to the respective amounts reported on Line (L) and enter the result on Line (N).

Annual Assessment Rate - Lines (O) and (P): The regional covered lives annual assessment rates for individual and family unit covered lives are provided in Line (O) and Line (P), respectively**.** These rates may not be changed by reporting entities.

Annual Assessment - Lines (Q) through (T):
Line (Q) Individual Unit: Line (M) multiplied by Line (O).
Line (R) Family Units: Line (N) multiplied by Line (P).
Line (S) Totals: Line (Q) plus Line (R).
Line (T) Total Covered Lives Payment Liability: Line (S) divided by 12.

Total Covered Lives Assessment Balance Due for the Year - Line VIII: The total covered lives assessment balance due for the year is the sum of the regional amounts entered on Line (T).

GENERAL INSTRUCTIONS FOR COMPLETING PRIOR SERVICE YEAR PORTIONS OF THE REPORT OF COVERED LIVES ASSESSMENT

On top of the form, check all the reporting circumstances which apply.

For the previous service year portion of the report:

Box 1: Enter an "X" if the payor has no adjustments for covered lives information previously reported for the previous service year. If an annual reporter erroneously submitted monthly reports during the current reporting year, enter an "X" if the payor has no additional adjustments for covered lives information previously reported for the previous service year.

Box 2: Enter an "X" if the payor has made no patient services payments during the reporting year for services rendered during the previous service year and has no adjustments to patient services payments previously reported for the previous service year. If the annual reporter erroneously submitted monthly reports during the current reporting year**,** enter an "X" if the payor has no additional patient services payments to report for services rendered during the previous service year **and** no additional adjustments to patient services payments previously reported for the previous service year.

Box 3: Enter an "X" if the payor's Report of Patient Services Payments and Surcharge Obligations is being reported separately by the fund or a TPA.

The only amounts to be reported on prior service year portions of the Report of Covered Lives Assessment are prior period adjustments. Thus, the instructions for prior service year portions of the Report of Covered Lives Assessment begin with Lines (M) and (N).

Total Covered Lives - Lines (M) and (N): Enter the number of covered lives under or (over) reported for prior periods (Prior Period Adjustments), by region. For example, if the payor failed to report four family unit covered lives that were on the payor's membership roles for all or any part of six months, the payor would enter 24 under the appropriate family unit regional designation on Line (N) of this section of the report. Prior period adjustments include retroactive additions and deletions to membership. Since covered lives payments are due for any plan participant on the membership rolls for all or any part of a month, retroactive deletions apply only when the individual or family unit is being retroactively deleted for full monthly periods.

For example, if one family unit covered life was originally included in the January 2002 through June 2002 monthly reports and was subsequently deleted effective January 5, 2002, the payor would enter - 5 under the appropriate family unit regional designation on Line (N) of the report to reflect the deletion of one family unit covered life for five months (February through June 2002). Further, the net number of monthly covered lives under or over-reported for prior periods must reflect any apportionments if the lives being adjusted were previously subject to apportionment. For example, if ten family unit covered lives were being retroactively deleted for one month and pursuant to an apportionment agreement this payor shared costs at a fifty percent (50%) level, only - 5 lives would be shown under the appropriate family unit regional designation on Line (N) of this section of the report.

If an annual reporter erroneously submitted monthly reports during the current reporting year, the prior period adjustment amounts reported on Lines (M) and (N) of the annual report must account for any remaining adjustments to covered lives previously reported for the specified service year.

Annual Assessment Rate - Lines (O) and (P): The regional covered lives annual assessment rates for individual and family unit covered lives are provided in Line (O) and Line (P), respectively. These rates may not be changed by reporting entities.

Annual Assessment - Lines (Q) through (T):
Line (Q) Individual Unit: Line (M) multiplied by Line (O).
Line (R) Family Units: Line (N) multiplied by Line (P).
Line (S) Totals: Line (Q) plus Line (R).
Line (T) Total Covered Lives Payment Liability: Line (S) divided by 12.

Total Covered Lives Assessment Balance Due for the Year - Line VIII: The total covered lives assessment balance due for the year is the sum of the regional amounts entered on Line (T).

WIRE TRANSFERS:

Payors may wire transfer Public Goods Pool payments to the Department's Office of Pool Administration. Payors must complete and submit the Wire Transfer form. Payors that wire transfer their Public Goods Pool payment to the Department's Office of Pool Administration must fax a copy of the completed Wire Transfer form to the Office of Pool Administration 24 hours prior to completing the wire transfer. Additionally, payors must submit a copy of the completed Wire Transfer form with the applicable Certification and reporting form(s). Please follow closely the instructions listed at the bottom of the Wire Transfer form.

Example - Weighted Average Apportionment Calculation

NYC Region	1,000 Lives - All Individual 100 Lives Subject to Apportionment

Agreement #	# of Lives Subject to Apportionment.	This Payors Apportionment %	Apportioned Covered Lives
1	30	20%	6
2	50	30%	15
3	20	0%	0
Total	100		21

Apportionment Percentage = 21 / 100 or 21%

or 21 lives at $116.04 = $2,436.84

PROOF:

Individual Covered Lives Rate	Agreement #	# of Lives Subject to Apport.	Full Assessment Calculation	Apportionment %	Apportioned Liability
$ 116.04	1	30	3481.20	20	$ 696.24
$ 116.04	2	50	5802.00	30	1,740.60
$ 116.04	3	20	2320.80	0	0
					$ 2,436.84